

MEDICAL BOARD STAFF REPORT

DATE REPORT ISSUED: December 14, 2018
ATTENTION: Members, Medical Board of California
SUBJECT: American Board of Cosmetic Surgery's Application for
Specialty Board Equivalency Recognition in California
STAFF CONTACT: April Alameda, Chief of Licensing

REQUESTED ACTION:

After review and discussion, determine whether American Board of Cosmetic Surgery (ABCS) meets the requirements of California Business and Professions Code (BPC) section 651(h)(5)(C), and Title 16, Division 13, California Code of Regulations (CCR), section 1363.5 to be deemed equivalent with member boards of the American Board of Medical Specialties (ABMS).

BACKGROUND AND ANALYSIS:

In 1990, Senate Bill 2036 (McCorquodale, Chapter 1660) sought to prohibit physician advertising about "board certification" that would mislead consumers. The advertising of "board certification" implies that physicians have been formally trained and tested in a given field, and the concern was that physicians were claiming to be "board certified" without obtaining the training and credentials to support the assertion. Consequently, the purpose of the bill was to ensure consumer protection and promote consumer confidence by only allowing physicians to advertise they are "board certified" if they have been certified by boards meeting requirements set forth by law and regulation.

Originally, the bill prohibited physicians from advertising they were board certified unless the board was an ABMS member. After opposition from non-ABMS approved specialties emerged, the bill was amended to include two alternatives to define legitimate specialty boards.

Thus, pursuant to BPC section 651(h)(5)(C), a physician may only advertise that he or she is board certified if he or she is certified by: 1) a member board of the ABMS; 2) a board or association with an Accreditation Council for Graduate Medical Education (ACGME) approved postgraduate training program that provides adequate training in that specialty; or 3) a specialty board or association with equivalent requirements to ABMS specialty boards approved by the Medical Board of California (Board).

It is important to note that the law does not prohibit the advertising of specialization, regardless of board certification status. Consequently, physicians who are certified by non-recognized boards are still able to practice their specialties, and advertise that they practice in that specialty; they simply cannot use the term "board certified."

To be approved by the Board, a specialty board applicant must demonstrate it is equivalent to a related ABMS board, and that it complies with the provisions of BPC

section 651(h)(5)(C), and CCR section 1363.5. The requirements under CCR section 1363.5 include, but are not limited to:

- The primary purpose of the specialty board is certification in a medical specialty or subspecialty and does not restrict itself to a single method of treatment;
- The specialty board is a nonprofit corporation or association with at least 100 members holding a clear and unrestricted license, and has articles of incorporation, a constitution, or a charter and bylaws to describe its operation, process for applicants, comprehensive evaluation of the knowledge and experience of applicants;
- The specialty board must have standards for its members to ensure the knowledge, skills and overall competency to provide care in the specified specialty or subspecialty;
- More than 80 percent of the specialty board's revenue for continuing operations shall be from certification and examination fees, membership fees and interest and investment income;
- Unless another pathway applies, the specialty board must require applicants to complete a postgraduate training program accredited by the ACGME or the Royal College of Physicians and Surgeons of Canada (RCPSC) that includes identifiable training in the specialty or subspecialty. This identifiable training shall be deemed acceptable unless determined to be either:
 - (1) inadequate in scope, content and duration in that specialty or subspecialty in order to protect the public health and safety; or
 - (2) not equivalent in scope and content to the residency training required for board certification by any related ABMS board for the specific conditions, disease processes and surgical procedure within the scope of the applicant certifying board's examination and certification.
- The specialty board shall require all physicians who are seeking certification to successfully pass a written or an oral examination or both which tests the applicants' knowledge and skills in the specialty or subspecialty area of medicine.
- The specialty board shall assist in maintaining and elevating the standards of graduate medical education and facilities for specialty training in medicine, and have a mechanism for assisting accrediting agencies in the evaluation of training programs.

The ABCS submitted an application to the Board requesting recognition to be deemed equivalent to an ABMS board. After Board staff completed its review, the application and supporting materials were forwarded to Neal W. Fleming, M.D., PhD, Professor of Clinical Anesthesiology at the University of California Davis, in the Department of Anesthesiology and Pain Medicine, for review and recommendation.

Dr. Fleming's review focused on the quality of ABCS' medical education programs and whether they met the requirements for equivalency to ABMS member boards.

At the October 18, 2018, Board meeting, Dr. Fleming presented his findings to the Board, and based on the application and supporting documents provided by ABCS, Dr. Fleming did not recommend approval because ABCS did not demonstrate meeting the training requirements set forth under CCR section 1363.5(b)(8). Specifically, Dr. Fleming's review determined that ABCS's training for board certification does not adequately prepare its members and is not equivalent to the training required by specialty boards recognized by ABMS.

After further discussion by the Board, rebuttal and deliberation, the Board highlighted questions and concerns to be brought back to the Board for further review and consideration. As a result, on November 14, 2018, Board staff sent a letter to ABCS outlining the questions asked by the Board and seeking the additional information requested by Dr. Fleming. ABCS responded to this letter and provided additional information and supplemental documentation on November 26, 2018. This information was forwarded to Dr. Fleming for review and a final report.

Based on Dr. Fleming's review, ABCS has not met the training requirements set forth under CCR section 1363.5(b)(8) and is not equivalent to the training required by specialty boards recognized by ABMS.

ATTACHMENTS:

1. Neal W. Fleming, M.D.'s Supplemental Report Regarding the American Board of Cosmetic Surgery's Application for Specialty Board equivalency Recognition in California, dated December 14, 2018
2. Neal W. Fleming, M.D.'s Initial Report Regarding the American Board of Cosmetic Surgery's Application for Specialty Board Equivalency Recognition in California, dated October 3, 2018
3. California Business and Professions Code section 651
4. California Code of Regulations, Title 16, Division 13, section 1363.5

*Please Reply to:*

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SCHOOL OF MEDICINE
DAVIS, CALIFORNIA 95616

December 14, 2018

A handwritten signature in black ink, appearing to read "N. Fleming", is written over a horizontal line.

Follow-up Report

American Board of Cosmetic Surgery

Request for determination of equivalency by the California Medical Board

Background

For the purposes of specialty medical board advertising, the Business and Professions Code section 651(h)(5)(A)&(B) prohibits physicians from advertising that they are board certified unless they are certified by:

1. An American Board of Medical Specialties member specialty board
2. A specialty board with an ACGME accredited postgraduate training program
3. A specialty board with "equivalent" requirements approved by the Medical Board of California's Licensing Program.

The American Board of Medical Specialties is comprised of 24 Medical Specialty Boards that oversee 39 medical specialties and 86 sub-specialties. For the specialty board or association to be approved as being equivalent by the Division of Licensing it must comply with multiple administrative requirements, including as examples:

- The specialty board shall be a nonprofit corporation or association, and it shall have at least a total of 100 members located in at least one-third of the states who shall possess a clear and unrestricted license to practice medicine.
- The specialty board shall have articles of incorporation, a constitution, or a charter and bylaws which describe its operation.
- More than 80 percent of the specialty board's revenue for continuing operations shall be from certification and examination fees, membership fees and interest and investment income.

These and other similar requirements have been reviewed by your support staff and overall are felt to have been adequately address in the ABCS application packet.

Based upon past history and my initial review, the primary requirement of concern was that for equivalency, the certification program must have been "determined by the Division of Licensing to be equivalent in scope, content and duration to those of an ACGME or RCPSC accredited program in a related specialty or subspecialty area of medicine." The initial ABCS application referenced Fellowship Training Program Guidelines that are modeled after ACGME accreditation guidelines, however, my initial review highlighted a concerning discordance between these ABCS Training Guidelines

and the fellowships as portrayed on ACCS website and an absence of supporting documentation that was sought through other resources. The presentation of this initial review to the Board, the rebuttal and subsequent discussion highlighted questions and concerns that were subsequently addressed with a request for additional clarifying and supporting documentation from the ABCS. These requests and a review of the responses and documentation provided are summarized below.

Concerns, Requested Materials, Review

Concern: There are multiple residency pathways for ABCS Fellowship qualification. Some have been eliminated (Clinical Experience -2014, Dermatology – 2016). The magnitude of the impact of grandfathering physicians certified under these pathways is not clear.

Request: *Please provide a list of all physicians currently certified by the ABCS that includes their qualification pathway and current state licensures.*

Response: The following list was provided. It does not include any state licensure information.

9:34 AM
11/02/18

The American Board of Cosmetic Surgery, Inc.

Customer Contact List

Customer	Specialty	Certified (ABCS YYYY)	Certified In	Certification Route
Ali Khan, Husain (Bagheri)	Oral Maxillofacial	ABCS 2012	General	Fellowship Route
Bailey, MD, Colin E.	General Surgery & Thoracic Sur	ABCS 2012	General	Fellowship Route
Castellese, MD, Nicole Marie	General Surgery	ABCS 2012	General	Fellowship Route

Review: The list includes 366 certified physicians.

Certification year (1979 – 2017)	n	%
Blank	1	0
79 -89	85	23
90 - 99	61	17
00 - 09	78	21
10 - 17	141	39
15 - 17	41	11

Qualifying Residency	n	%
Otolaryngology	111	30
General Surgery	67	18
Oral & Maxillofacial	61	17
Dermatology	37	10
Ophthalmology	34	9
OB/GYN	20	5
Misc: "AOA", Internal Med, Ital.Bd.of Vasc.Surg, "Osteopathic", blank(11)	15	4
Plastic Surgery	14	4
Facial Plastic & Reconstructive Surgery	4	1
Oculoplastic Surgery	3	1

Certified In:	n	%
General	254	69
Facial	63	17
Dermatologic	33	9
Body, Breast & Extremity	15	4

Blank	1	0
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Certification Route	n	%
Fellowship	137	37
Experience, Grandfathered, Voluntary	119	33
Blank (1980 - 2003)	110	30

Assessment: It is a minority of the currently certified physicians who completed the training program currently being considered for equivalency. 10% of currently certified physicians qualified through a residency no longer considered to be acceptable. It is not possible to determine the immediate impact of this change on California because no state licensure information was provided.

Concern: There was inconsistency between the Fellowship Training Guidelines submitted to the California Medical Board as part of the application and documentation on the AACS website with respect to qualifying residency training pathways.

Request: *Please confirm that the Fellowship Training Guidelines submitted to the California Medical Board as part of the application are current and consistent with documentation on the AACS website.*

Response: The current guidelines are published on the AACS website:
https://cdn.ymaws.com/www.cosmeticsurgery.org/resource/resmgr/docs/10.2017_General_Fellowship_G.pdf

Review: Done.

Concern: Ophthalmology still presents a non-surgical qualifying residency. It must be followed by an ophthalmic plastic and reconstructive surgery residency, but then requires a two year cosmetic surgical fellowship instead of a single year. The implication is that the residency training program does not provide a complete foundation for the cosmetic surgical fellowship.

Request: *Beyond duration, how is the training curriculum modified for candidates in this pathway to assure they receive complete, comprehensive fellowship training?*

Response: To be approved for the ABCS certification exam, a candidate with an ophthalmology residency background is required to complete a two-year AACS certified Fellowship.

Review: The ABCS response cover letter expands a bit further arguing that ophthalmology can, in fact, be considered to be a surgical residency. Furthermore, the required subsequent oculoplastic fellowship adds substantial surgical experience and was felt by the fellowship guideline review and development committee to provide a more relevant year of training than a year of general surgical training.

Assessment: These arguments with respect to general surgical training and exposure seem reasonable, yet there remains a disconnect in that there is still a requirement for a doubling of the duration of the cosmetic surgical fellowship training time and case experience but there is no commensurate modification of the educational curriculum to address the deficiencies implied by the training modifications.

Concern: According to the Fellowship Training Guidelines, the Program Director must be certified by the ABCS have an academic appointment and be engaged in verifiable scholarly activities.

Request: Please provide a list of all current program directors, confirm their active status as fellows of the AACCS/ABCS and provide a summary of their recent scholarly activities.

Response: One file listing 26 program directors was provided. A second file with 28 names including AACCS fellowship ID numbers was also provided. Every name on the first list was also on the second list. CV files were provided for 24 of the 26 program directors.

Assessment: No collated summary of recent scholarly activities was provided. The CVs provided were highly variable with respect to format and content. Academic appointments or affiliations were rarely included in the CVs provided and must be assumed not to exist. A review of the documents provided could be concisely summarized to say that as a whole, the fellowship training program directors are also not consistently engaged in verifiable scholarly activities.

Concern: Similar expectations are required of the affiliated faculty with respect to academic appointments and scholarly activities.

Request: Please provide this same information (academic appointments and scholarly activities) for affiliated faculty in each program.

Response: 11 folders were provided with 10 had names of current program directors. Each folder contains either a brief summary or a more structured CV for anywhere from 1 to 5 faculty that I assume are associated with that training program. Some CVs appear in multiple folders.

Assessment: Again, no collated summary of academic appointments or recent scholarly activities was provided. The CVs provided were again highly variable with respect to format and content. Academic appointments or affiliations were rarely included in the CVs provided and again must be assumed not to exist. A review of these documents as provided could again be concisely summarized to say that as a whole, the fellowship training program affiliated faculty are also not consistently engaged in verifiable scholarly activities.

Concern: According to the Fellowship guidelines, the programs must ensure that sufficient academic support exists to enable the Fellow in training to meet all program requirements.

Request: Please provide a summary of what would be considered to meet the expectations for "sufficient academic support" and a corresponding summary of how each training program meets or exceeds these expectations.

Response: The cover letter response is focused more on the training environment but adds this global summary: The fellows are provided with the core curriculum, a recommended reading list with texts and articles that are easily accessible in the program director's library. In addition, the fellows have access to American Journal of Cosmetic Surgery, The Plastic and Reconstructive Surgery Journal as well as the Aesthetic Journal. In addition they have full access to a medical library through the local academic hospital or hospital where the director has privileges. The referenced folder provides this summary: Ensuring the training fellows is getting the appropriate academic support is a focus of the site visit. Please review the Guidelines for Program Accreditation document enclosed in this file. The questions asked of the Training Fellow are based on ensuring that they are getting the academic support they need.

Two training program site evaluations are included. Ex:

Facilities and Resources:

Institutional facilities and the physical plant are adequate to provide the educational experiences and opportunities required to fulfill the needs of the educational program.

☒ Yes ☐ No

A library with standard reference texts and current journals is available to the fellow, including *The Art of Aesthetic Surgery* by Foad Nahai, MD.

☒ Yes ☐ No

Assessment: This requirement was a component of the comments presented by the American Society of Plastic Surgeons at the initial review. The requirements as described in the guidelines are limited and not consistent with those of comparable ACGME accredited training programs. Furthermore, no documentation is provided to assure that even these most minimal of requirements are consistently provided by the training programs.

Concern: The Fellow-in-Training must perform clinical or basic research, and, as part of the program, and submit at least one clinical or basic research paper reflecting said research for publication to the *American Journal of Cosmetic Surgery* (AJCS) or another peer-reviewed Cosmetic / Plastic Surgery journal.

Request: Please provide a summary of the submissions completed by the fellows to meet this expectation for the past 3 years.

Response: 4 folders of documentation were provided. One folder labeled 2016 Training Fellow Submission included documentation of the submission of 10 manuscripts to the AJCS. A second folder labeled 2017 Training Fellow Submission included documentation of the submission of 9 manuscripts to the AJCS and 4 abstracts to the annual society meeting. The third folder labeled 2018 Training Fellow Submission included documentation of the submission of manuscripts by what I assume to be 13 fellows to the AJCS or other journals. The fourth folder labeled 2016-September 2018 Program Director AJCS Publications included 7 manuscripts in the AJCS co-authored by fellows (I presume). Some of these were presented as abstracts or were listed in the submitted manuscript folders. In addition, 3 folders contained abstracts from the 2016 -18 annual society meetings. Presentations by Program Directors and fellows were highlighted and included 1, 4 and 4 fellow presentation in 2016, 17 and 18 respectively.

Assessment: The data provided was not clearly summarized or edited for redundancy. This program training requirement is not consistently met by a majority of all fellows or all programs.

Concern: The core curriculum for Fellowship Training Programs is incorporated into the Fellowship Handbook available through links on the AACS website.

Request: A current copy of this handbook should be formally included with the application packet.

Response: The requested documentation was provided

Review: Done.

Concern: Each training program must have a formally structured curriculum containing including a summary of the overall educational goals, competency-based goals and a list of topics to be discussed in weekly seminars.

Request: *Please provide documentation of this expectation for each program.*

Response: All fellowship directors and faculty do this on a daily basis routinely as part of the training. In addition, the curriculum folder referenced contains a list of 50 discussion topics and a list of on-line AASC web clinics. There are about 6 of these presentations per year for the last 4 years. The Fellowship Orientation Handbook is also included in this folder. This included the Training Program Curriculum.

Assessment: Daily clinical discussions are distinctly different from a formally structured curriculum. There is no summary or educational goals or competency-based goals in the documentation provided. The documentation provided does not support the presence or use of a formally structured curriculum for each training program.

Concern: A monthly core curriculum review is mandatory for all fellows.

Request: *Is attendance/participation tracked or documented?*

Response: Supporting documents provided include schedules, sample programs and attendance records.

Assessment: This monthly schedule appears to have been consistent over the past 3 years. The 3 sample presentations provided appear comprehensive. Attendance as documented is pretty good.

Concern: The core curriculum in the Fellowship Handbook is a procedure oriented outline that runs just over 100 pages. The core competencies of patient care, medical knowledge, practice-based learning and improvement, communication skills, professionalism and systems based practice are clearly outlined in the Fellowship Training Guidelines.

Request: *Please explain the systems used to assure that the assessments of clinical case performance and the written/oral exam process adequately assure mastery of this core curriculum. In addition, how are the core competencies integrated in to the core curriculum and how are they specifically assessed for each Fellow?*

Response: The response cover letter provides an extensive description of the curriculum guidelines and their integration with each of the ACGME defined core competencies.

Assessment: The 6 month evaluations of the individual fellows are structured around the headings of *Intellectual*, *Technical* and *Personal*. Sub-sections for each of these can be related to core competencies and although they do not provide the overarching structure, they are largely covered in the arenas listed.

Concern: According to the Fellowship Training Guidelines, each training program must educate faculty and fellows to recognize signs of fatigue and sleep deprivation, alertness management and fatigue mitigation processes, and adopt fatigue mitigation processes to manage the potential negative effects of fatigue on patient care and learning.

Request: *Please provide a summary of how these expectations are met for each program and documentation of adherence.*

Response: Reference is returned to the program guidelines to sections addressing the need for awareness, education and sleep facilities. And the summary statement:

“Fellowship directors intervene on a case-by-case basis when signs of sleep deprivation or fatigue are present that may interfere with fellow safety or effect patient care.”

Assessment: No documentation is provided to support consistent formal education focused on this topic that is considered critical by the ACGME.

Concern: Cosmetic surgery fellowship training falls under current ACGME 80 hour work week guidelines.

Request: *How are duty hours monitored in each fellowship program? What percentage of Fellows participate in moonlighting activities? How are these activities monitored?*

Response: Moonlighting percentages are provided for the past 2 years (27% & 41%). The 80 hour work week parameters are to be discussed directly between the program director and fellow, and assessed on an ongoing basis throughout the duration of the length of the moonlighting experience.

Assessment: No documentation is provided to support any formal work hour monitoring. This would not meet expectations in an ACGME accredited training program.

Concern: Training program assessments and monitoring are essential to assure continued quality and guide improvements.

Request: *How are training programs assessed? With the limited numbers of fellows in each training program, how is feedback solicited in a fashion to assure anonymity and obtain objective information?*

Please provide a history of program assessments and evaluations. Have any programs been placed on probation? How were any corresponding remediations assessed?

Initial reviews suggested that many fellowship training program directors were also in leadership positions on the ABCS and the AACS and consequently directly involved in the assessment of training programs. What is the extent of this overlap? How is this potential conflict of interest mitigated?

Response: The fellows perform facility evaluations anonymously twice a year. The central office contacts the fellows by email and sends them a copy of the evaluation mid-year and prior to completion of the fellowship. The fellow returns the evaluation by email directly to the Academy office. The Fellowship Review Committee (FRC) reviews these evaluations in their quarterly meetings. Any score of less than 3, and consistent low scores, are investigated by the FRC.

Within the past three years, one fellowship program had their certification revoked because their ABCS certification was not maintained. Another program voluntarily ceased their fellowship when the Program Director became ill. No programs have been placed on probation.

It is quite common in medicine, and other fields, that leaders and educators are also involved in the leadership of the society that promotes education and safety in that arena.

Additional files are provided for the current Board of Trustees and General Fellowship Committee, blank forms for program assessment and 2 sample site survey reports

Assessment: With only 1 or 2 fellows per program per year, anonymity in evaluations requires substantial involvement of third parties. Solicitation of evaluations from administrative offices is good, but review by the general fellowship committee that has

50% of its' membership as program directors does not provide sufficient reassurance to individuals providing feedback. No documentation is provided to allow assessment of the quality or quantity of the evaluations received.

Overlap is indeed common for individuals in leadership positions, but concurrency and even perceived conflicts of interest should be vigorously avoided. The documentation provided does not support the contention that this is the case for these review and remediation processes.

Concern: Confirmation of many of these question might be best provided by contact with recent graduates rather than with current program directors.

Request: *Please provide a list of individuals that have been board certified in the last 12 months and their contact information.*

Response: Contact information was provided for 11 2017 fellows.

Assessment: Following review of the documentation provided, individual interviews of recent graduates were not pursued.

Conclusions

To review, for a training program to be accepted by the Division of Licensing to be equivalent, it must be so in scope, content and duration to those of an ACGME accredited program in a related specialty or subspecialty area of medicine. The current ABCS Fellowship Training Program Guidelines are modeled appropriately and closely after ACGME accreditation guidelines. However, these guidelines have only been in effect for a short number of years. Acceptance of ABCS certification as equivalent would necessarily encompass a majority of physicians who were not certified or trained under the current guidelines. In fact, they were certified under guidelines previously not felt to be acceptable to the Board as being equivalent and were felt to merit revision by the ABCS as well. More importantly, there were a number of arenas in which the initial documentation provided in the ABCS application did not support adherence to the training guidelines as presented. Subsequent evaluation of the supplemental documentation provided upon request has not supported the contention that the current ACCS fellowship training programs consistently adhere to the program training guidelines as provided by the ABCS. Current programs do not consistently meet the fellowship training guidelines developed and endorsed by the ABCS. They would not meet criteria for acceptance under current ACGME guidelines and therefore should not be considered as equivalent to an ABMS member specialty board.

MEDICAL BOARD STAFF REPORT

DATE REPORT ISSUED: October 11, 2018
ATTENTION: Members, Medical Board of California
SUBJECT: American Board of Cosmetic Surgery's Application for
Specialty Board Equivalency Recognition in California
STAFF CONTACT: April Alameda, Chief of Licensing

REQUESTED ACTION:

After review and discussion, determine whether the American Board of Cosmetic Surgery (ABCS) meets the requirements of California Business and Professions Code (BPC) section 651(h)(5)(C), and Title 16, Division 13, California Code of Regulations (CCR), section 1363.5 to be deemed equivalent with member boards of the American Board of Medical Specialties (ABMS).

BACKGROUND AND ANALYSIS:

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Thus, pursuant to BPC section 651(h)(5)(C), a physician may only advertise that he or she is board certified if he or she is certified by: 1) a member board of the ABMS; 2) a board or association with an Accreditation Council for Graduate Medical Education (ACGME) approved postgraduate training program that provides adequate training in that specialty; or 3) a specialty board or association with equivalent requirements to ABMS specialty boards approved by the Medical Board of California (Board).

It is important to note that the law does not prohibit the advertising of specialization, regardless of board certification status. Consequently, physicians who are certified by non-recognized boards are still able to practice their specialties, and advertise that they practice in that specialty; they simply cannot use the term "board certified."

To be approved by the Board, a specialty board applicant must demonstrate it is equivalent to ABMS boards, and that it complies with the provisions of BPC section

651(h)(5)(C), and CCR section 1363.5. The requirements under CCR section 1363.5 include, but are not limited to:

- The primary purpose of the specialty board is certification in a medical specialty or subspecialty and does not restrict itself to a single method of treatment;
- The specialty board is a nonprofit corporation or association with at least 100 members holding a clear and unrestricted license, and has articles of incorporation, a constitution, or a charter and bylaws to describe its operation, process for applicants, and a comprehensive evaluation of the knowledge and experience of applicants;
- The specialty board must have standards for determining its members passes the knowledge, skills and overall competency to provide care in the specified specialty or subspecialty;
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 - (1) inadequate in scope, content and duration in that specialty or subspecialty in order to protect the public health and safety; or
 - (2) not equivalent in scope and content to the residency training required for board certification by any related ABMS board for the specific conditions, disease processes and surgical procedure within the scope of the applicant certifying board's examination and certification.
- The specialty board shall require all physicians who are seeking certification to successfully pass a written or an oral examination or both, which tests the applicants' knowledge and skills in the specialty or subspecialty area of medicine.
- The specialty board shall assist in maintaining and elevating the standards of graduate medical education and facilities for specialty training in medicine, and have a mechanism for assisting accrediting agencies in the evaluation of training programs.

On December 21, 2015, the ABCS submitted an application to the Board requesting recognition to be deemed equivalent to an ABMS board. Board staff sent a letter identifying deficiencies and seeking additional information on February 19, 2016. ABCS responded to this letter and provided additional information on November 11, 2016.

Thereafter, the Board had several additional inquiries and required written explanations and supporting documents from ABCS.

After Board staff completed its review, the application and supporting materials were forwarded to Neal W. Fleming, M.D., PhD, Professor of Clinical Anesthesiology at the University of California Davis, in the Department of Anesthesiology and Pain Medicine, for review and recommendation. Dr. Fleming's review focused on the quality of ABCS' medical education programs and whether they met the requirements for equivalency to ABMS member boards.

Based on Dr. Fleming's review, ABCS has not met the training requirements set forth under CCR section 1363.5(b)(8), in that the training required for ABCS board certification does not adequately prepare its members and is not equivalent to the training required by specialty boards recognized by ABMS.

ATTACHMENTS:

1. Neal W. Fleming, M.D.'s Report Regarding the American Board of Cosmetic Surgery's Application for Specialty Board Equivalency Recognition in California
2. California Business and Professions Code section 651
3. California Code of Regulations, Title 16, Division 13, section 1363.5



Please Reply to:

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SCHOOL OF MEDICINE
DAVIS, CALIFORNIA 95616

October 3, 2018

To: Medical Board of California - Licensing Program
Attn: April Alameda, Chief of Licensing

From: Neal W. Fleming, MD, PhD
Vice-Chair for Education
Director, Cardiovascular and Thoracic Anesthesiology
Department of Anesthesiology & Pain Medicine
UC Davis School of Medicine

A handwritten signature in black ink, appearing to read "N. Fleming MD".

Re: American Board of Cosmetic Surgery application for specialty board equivalency recognition in California

Primary Request:

I was contacted by the Medical Board of California (Board) and asked to review and comment on the application by the American Board of Cosmetic Surgery (ABCS) for approval as a medical specialty board for purposes of advertising.

Personal Background:

I am currently a Professor of Clinical Anesthesiology in the Department of Anesthesiology & Pain Medicine at the University of California, Davis. I work as an anesthesiologist at the UC Davis Medical Center in Sacramento and serve as the Director of Cardiovascular & Thoracic Anesthesia and as the Vice-Chair for Education. I am board certified in Anesthesiology, by the American Board of Anesthesiology and board certified in Advanced Perioperative Transesophageal Echocardiography by the National Board of Echocardiography. The majority of my career has been in the academic practice of anesthesiology.

I am extremely familiar with the requirements for training at the post-graduate resident and fellowship levels as overseen by the Accreditation Council for Graduate Medical Education (ACGME) and the American Board of Medical Specialties (ABMS). I have been involved in the training and assessment of residents and fellows in a variety of roles. In addition to daily clinical bedside instruction, and more formal didactic

presentations, I have served as a Core Residency Program Director for an anesthesiology residency training program, as a Fellowship Program Director for an adult cardiothoracic anesthesiology program and Chair of our Departmental Clinical Competency Committee, charged with the oversight and review of all resident evaluations, the preparation and reporting of Milestone progress and advising the Core Program Director regarding resident progress, including promotion, remediation and dismissal.

Materials Reviewed:

Application for Approval of a Medical Specialty Board Conferred by the American Board of Cosmetic Surgery, Inc. Submitted 12/8/15 (Binders 1 through 3).

Primary and Supplemental Report on the initial proposal for the American Board of Cosmetic Surgery's Application for Specialty Board Equivalency Recognition in California Submitted 10/17/2005.

Application of the American Board of Sleep Medicine to be recognized as equivalent to an ABMS specialty board for the purpose of advertising as an example of a report (for format). Submitted 1/16/98.

American Academy of Cosmetic Surgery (AACS) website (<https://www.cosmeticsurgery.org/>), AACS certified Cosmetic Surgery Fellowships page. Multiple access, September and October, 2018.

Historical Context:

The ABCS was formed in 1979 to promote the safe and ethical practice of cosmetic surgery. Specific goals and objectives include establishing and maintaining the highest professional standards in cosmetic surgery and establishing a method for the qualification of specialists in cosmetic surgery and a certification system. The ABCS works in conjunction with the AACS, the organization that oversees the clinical fellowship training programs required to meet the qualifications for sitting for the board certification examinations in cosmetic surgery as granted by the ABCS.

In 1996, the ABCS submitted an application for certification as a specialty board to the Board. This request was subsequently disapproved in 1997. Following this rejection, the ABCS retained legal counsel to review the board certification processes and recommend improvements intended to meet current American Board of Medical Specialties (ABMS) standards. Several revisions were subsequently made to the guidelines and requirements for certification. At this time, the ABCS chose not to apply for ABMS recognition since only one certifying board in each specialty is recognized by this board and that is currently the American Board of *Plastic* Surgery (ABPS).

In June 2003 ABCS submitted an application to the Board for recognition in California as being "equivalent" to member boards of the ABMS, for the purposes of advertising. This request was denied for multiple reasons, foremost among them being

the disparate pathways available for ABCS certification qualification and the inability to be certain that each pathway provided consistently sufficient training to assure patient safety and quality of care. Particular concern was expressed regarding the background provided by prior residency training certification by the American Board of Dermatology.

In December of 2015 the ABCS submitted a new application to the Board for recognition in California as being "equivalent" to member boards of the ABMS, for the purposes of advertising. Since the previous (2003) application, a number of significant modifications have been made to both the training pathways and the final certifications. These include:

- Condensation of 4 sub-certifications (Body, Breast & Extremity, Dermatologic, Facial and General) in to a single Cosmetic Surgery certification.
- Elimination of the Clinical Experience pathway to meeting the requirements to sitting for the certification examinations (2014).
- Elimination of the American Board of Dermatology as a core board route to certification (2016).

With respect to these changes, there was a query from the Board included in the application packet asking if there is a mechanism for control of physicians currently holding board certification in cosmetic surgery who entered and qualified for the examinations through pathways that are no longer recognized because they were considered to be inadequate? In response, the ABCS replied that only three certified physicians are still in practice who received certification following a dermatology residency. No similar information was provided for certified physicians who entered via the clinical experience pathway.

Application Review:

I have reviewed the original application and the entire collection of supplemental materials. Many components of this packet seem to be adequately addressed. Guided by my own areas of expertise, the focus of this review is on the fellowship training programs and an assessment of the ability of these programs to provide consistent training that meets published guidelines and result consistently in providing the intended expertise in the trainees to assure the safety of their service as advertised, and to be deemed equivalent to ABMS boards.

Clinical Fellowship Training:

The Fellowship training programs are approved and overseen by the AACS. The argument presented in support of the need for this training is that the core residency pathways do not include adequate training to render a physician competent to perform the vast array of cosmetic surgical procedures that are covered by the ABCS certification. In general, these program guidelines mirror standard ACGME guidelines for residency training. One inconsistency that has not been addressed is that the fellowship training program requirements as described in the submitted packet still include dermatology as a viable core training pathway although it is no longer considered to be so by the ABCS. One additional concern is that no content outline is provided for the educational programs. This increases the opportunities for variations in

training as it relates to the Core Competency of medical knowledge. Along this same line, there is no mention of how the educational program should be modified for fellows entering through residency programs associated with the need for additional training (ophthalmology) other than a doubling of the duration of fellowship training and doubling the minimal case number requirements.

To provide some structure for this review, there are some key training program requirements for a cosmetic surgery fellowship that I would like to highlight:

Program Directors must have academic appointments, be an active fellow of the AACS, be engaged in verifiable scholarly activities and foster an environment that educates fellows in core competencies and maintains a quality didactic and clinical education. In addition, the majority of the core faculty in each program (must be at least 2) must also have academic appointments and demonstrate evidence of scholarly activity.

Qualified (fellowship sponsoring) Institutions must ensure sufficient academic support exist to comply with program requirements.

Facilities and Resources must be adequate to provide educational experiences and opportunities and include access to educational resources.

Educational Programs must have a formal structured curriculum including weekly seminars, a reading list of landmark publications, regularly scheduled didactic sessions and a broad and complete sequence of patient experiences.

Core Competencies are provided. These are standard for ACGME accredited programs and include: patient care, medical knowledge, practiced-based learning improvement, communication skills, professionalism and systems based practice.

Required Scholarly Activities for the fellow include: application of research methods and evaluation of data to guide interpretation of scientific literature, clinical research, submission of one clinical or basic research paper to the American Journal of Cosmetic Surgery (or similar journal) within 24 months of fellowship completion, participation and presentation at educational conferences and submission of an abstract for presentation at the AACS Annual Symposium.

Review of Approved Training Programs:

The approved fellowship programs are listed on the AACS website. Currently (10/1/2018) 32 programs are listed. Fellowships are offered for both general cosmetic surgery and facial cosmetic surgery. No distinction is provided as to which programs are approved for which fellowship training.

Of the Program Directors listed, two include their academic appointments. One of these is dermatology, a residency training pathway that has been eliminated. Active fellowship status in the AACS was not researched. Verifiable scholarly activities can take multiple forms. Some program directors appear to

be more active in non-peer-reviewed educational or training programs. A PubMed search of authorship for each name provides one verifiable perspective of scholarly activity that is widely used. Of the 35 program directors listed, 18 have less than 5 citations, 11 of these have no citations, one has 12 listings, one has 35, and one has 161. This may be the result of their primary journal (American Journal of Cosmetic Surgery) not being indexed on PubMed. Other affiliated faculty members were not searched and may have additional peer-reviewed activities. The final Program Director expectation – “foster an environment that educates fellows in core competencies and maintains a quality didactic and clinical education” is even harder to quantitate. A subjective review of the summary presentations for the training programs does not provide the impression that this is considered to be an important characteristic to emphasize. In addition, many of these program directors also have past or current active leadership roles on the ABCS or officers of the AACCS. I am not certain if this presents a bias or conflict of interests.

Seventeen of the 32 summaries included comments on the facilities available at the primary qualified sponsoring institutions. All of these are all stand-alone accredited surgical centers. Many mention their affiliations with nearby hospitals for referral support or opportunities for more complex cases. It is not clear if any of these institutions have academic affiliations. The majority of the descriptions for these practices and facilities seem to emphasize selected areas of focus or expertise. Rarely, the opportunities for comprehensive or broad based exposure to all four of the previous sub-certification arenas (body, breast & extremity, dermatologic, facial and general) are documented.

The educational program is specifically mentioned in 9 of the 32 summaries. Most comment on the daily instruction and teaching that occurs with most patients. Five of the summaries mention weekly didactic lectures. One summary provides the following comment: “This program is NOT for the timid. The ideal candidate must be ready for intense exposure and heavy surgical involvement from day one until the final hour of fellowship”. Another provides the following comment: “there are no vacations on this short fellowship”. Four of the summaries highlight the availability of educational resources, most typically as a comment such as: “Fellows have an office with access to an extensive library”.

Core competencies are not specifically addressed in any of the summaries, but a representative synopsis of overarching goals and objectives would be: “The fellows are involved with all aspects of a cosmetic surgery practice. Working closely with the physician, office administrators, and marketing director, fellows will be equipped with the knowledge for their own practice. Fellows are directly involved with patient care including: consultation, pre-op, marking, surgery, post-operative follow up, treatment of complications, and practice management”.

The required scholarly activities received mention in 9 of the 32 summaries. Six refer to the expectation and support for annual meeting attendance and five refer to the expectation for completion of a manuscript suitable for peer reviewed publication. No data is provided regarding the level of adherence to these expectations either for the

fellowships as a whole or for the individual programs. Eight summaries emphasize the expected case exposure, ranging from 400 to 1000 (average ~700).

An annual stipend was included on 19 of the summary pages. Offers ranged from \$24,000 to \$54,000 with an average of ~\$34,000. The 2016-17 ACGME average PGY5 salary was ~\$63,000. Five of the summaries include mention of the opportunities for moonlighting. None mention that these activities would still fall under the ACGME 80 hour total work week restriction.

Assessment Summary:

The primary purpose of the ABCS is to promote the safe and ethical practice of cosmetic surgery. Core to this goal, and a primary condition for recognition, is the requirement to assure that the applicants have received adequate preparation in accordance with the standards for training established by the specialty board. The fellowship training guidelines for certification in cosmetic surgery are consistent with other specialty residency and fellowship training guidelines. They are not entirely consistent with the ABCS requirements for certification in that they still include dermatology as a qualifying pathway for fellowship training and certification. In addition, the absence of a content outline for the fellowship educational program provides an opportunity for variations in the didactic components of training that increase the potential for inconsistent preparation. Furthermore, Ophthalmology remains as a qualifying residency pathway that has a core skill set distinct from the other surgically based qualifying residencies. This distinction is addressed by an increased duration of training and increased minimum case numbers, but the deficiencies in core competencies and specific pathways for remediation are not addressed in the training guidelines.

Of greater concern is the assessment of the approved fellowship training programs and their adherence to the training guidelines. It appears that current training programs, as a whole, do not consistently meet the spirit or the content of the recommended guidelines in multiple arenas and therefore do not provide consistently adequate preparation that meets standards used for other recognized fellowship certification training programs. The verifiable scholarly activity of the Program Directors does not appear to meet recommended program requirements as assessed by standards used by comparable programs. The educational resources provided by the sponsoring institutions, when listed, appear to be largely limited to a computer and maybe an office. The emphasis is on clinical case volume. It is not apparent that the training programs as described can consistently provide the broad based exposure to all aspects of cosmetic surgery as encompassed by the single certification. The educational programs are seldom highlighted by the presentations and the required scholarly activities are rarely acknowledged. No information is provided in the application regarding successful completion of the expectations established in the training guidelines for fellows who have completed training. When the annual stipends that run as low as 1/3 current ACGME approved fellowship salaries are combined with caseloads averaging 4 or 5 cases per day, it is hard to envision this training as anything other than low cost, high volume service support that cannot be considered equivalent to other approved specialty training certifications.

Conclusion:

Based upon my review, the training required for certification in cosmetic surgery as approved by the AACS is not equivalent to that required by other specialties currently recognized by the ABMS. In my opinion, the ABCS has not met the requirements to be deemed equivalent to an ABMS specialty board.

BUSINESS AND PROFESSIONS CODE

Section 651

651. (a) It is unlawful for any person licensed under this division or under any initiative act referred to in this division to disseminate or cause to be disseminated any form of public communication containing a false, fraudulent, misleading, or deceptive statement, claim, or image for the purpose of or likely to induce, directly or indirectly, the rendering of professional services or furnishing of products in connection with the professional practice or business for which he or she is licensed. A "public communication" as used in this section includes, but is not limited to, communication by means of mail, television, radio, motion picture, newspaper, book, list or directory of healing arts practitioners, Internet, or other electronic communication.

(b) A false, fraudulent, misleading, or deceptive statement, claim, or image includes statement or claim that does any of the following:

(1) Contains a misrepresentation of fact.

(2) Is likely to mislead or deceive because of a failure to disclose material facts.

(3) (A) Is intended or is likely to create false or unjustified expectations of favorable results, including the use of any photograph or other image that does not accurately depict the results of the procedure being advertised or that has been altered in any manner from the image of the actual subject depicted in the photograph or image.

(B) Use of any photograph or other image of a model without clearly stating in prominent location in easily readable type the fact that the photograph or image is of a model is a violation of subdivision (a). For purposes of this paragraph, a model is anyone other than an actual patient, who has undergone the procedure being advertised, of the licensee who is advertising for his or her services.

(C) Use of any photograph or other image of an actual patient that depicts or purports to depict the results of any procedure, or presents "before" and "after" views of a patient, without specifying in a prominent location in easily readable type size what procedures were performed on that patient is a violation of subdivision (a). Any "before" and "after" views (i) shall be comparable in presentation so that the results are not distorted by favorable poses, lighting, or other features of presentation, and (ii) shall contain a statement that the same "before" and "after" results may not occur for all patients.

(4) Relates to fees, other than a standard consultation fee or a range of fees for specific types of services, without fully and specifically disclosing all variables and other material factors.

(5) Contains other representations or implications that in reasonable probability will cause an ordinarily prudent person to misunderstand or be deceived.

(6) Makes a claim either of professional superiority or of performing services in superior manner, unless that claim is relevant to the service being performed and can be substantiated with objective scientific evidence.

(7) Makes a scientific claim that cannot be substantiated by reliable, peer reviewed, published scientific studies.

(8) Includes any statement, endorsement, or testimonial that is likely to mislead or deceive because of a failure to disclose material facts.

(c) Any price advertisement shall be exact, without the use of phrases, including, but not limited to, "as low as," "and up," "lowest prices," or words or phrases of similar import. Any advertisement that refers to services, or costs for services, and that uses words of comparison shall be based on verifiable data substantiating the comparison. Any person so advertising shall be prepared to provide information sufficient to establish the accuracy of that comparison. Price advertising shall not be fraudulent, deceitful, or misleading, including statements or advertisements of bait, discount, premiums, gifts, or any statements of a similar nature. In connection with price advertising, the price for each product or service shall be clearly identifiable. The price advertised for products shall include charges for any related professional services, including dispensing and fitting services, unless the advertisement specifically and clearly indicates otherwise.

(d) Any person so licensed shall not compensate or give anything of value to representative of the press, radio, television, or other communication medium in anticipation of, or in return for, professional publicity unless the fact of compensation is made known in that publicity.

(e) Any person so licensed may not use any professional card, professional announcement card, office sign, letterhead, telephone directory listing, medical list, medical directory listing, or a similar professional notice or device if it includes a statement or claim that is false, fraudulent, misleading, or deceptive within the meaning of subdivision (b).

(f) Any person so licensed who violates this section is guilty of a misdemeanor. A bona fide mistake of fact shall be a defense to this subdivision, but only to this subdivision.

(g) Any violation of this section by a person so licensed shall constitute good cause for revocation or suspension of his or her license or other disciplinary action.

(h) Advertising by any person so licensed may include the following:

(1) A statement of the name of the practitioner.

(2) A statement of addresses and telephone numbers of the offices maintained by the practitioner.

(3) A statement of office hours regularly maintained by the practitioner.

(4) A statement of languages, other than English, fluently spoken by the practitioner or a person in the practitioner's office.

(5) (A) A statement that the practitioner is certified by a private or public boarder agency or a statement that the practitioner limits his or her practice to specific fields.

(B) A statement of certification by a practitioner licensed under Chapter 7(commencing with Section 3000) shall only include a statement that he or she is certified or eligible for certification by a private or public board or parent association recognized by that practitioner's licensing board.

(C) A physician and surgeon licensed under Chapter 5 (commencing with Section 2000) by the Medical Board of California may include a statement that he or she limits his or her practice to specific fields, but shall not include a statement that he or she is certified or eligible for certification by a private or public board or parent association, including, but not limited to, a multidisciplinary board or association, unless that board or association is (i) an American Board of Medical Specialties member board, (ii) a board or association with equivalent requirements approved by that physician's and surgeon's licensing board prior to January 1, 2019, or (iii) a boarder association with an Accreditation Council for Graduate Medical Education approved postgraduate training program that provides complete training in that specialty or subspecialty. A physician and surgeon licensed under Chapter 5 (commencing with Section 2000) by the Medical Board of California who is certified by an organization other than a board or association referred to in clause (i), (ii), or (iii) shall not use the term "board certified" in reference to that certification, unless the physician and surgeon is also licensed under Chapter 4 (commencing with Section 1600) and these of the term "board certified" in reference to that certification is in accordance with subparagraph (A). A physician and surgeon licensed under Chapter 5(commencing with Section 2000) by the Medical Board of California who is certified by a board or association referred to in clause (i), (ii), or (iii) shall not use the term "board certified" unless the full name of the certifying board is also used and given comparable prominence with the term "board certified" in the statement.

For purposes of this subparagraph, a "multidisciplinary board or association" means an educational certifying body that has a psychometrically valid testing process, as determined by the Medical Board of California, for certifying medical doctors and other health care professionals that is based on the applicant's education, training, and experience. A multidisciplinary board or association approved by the Medical Board of California prior to January 1, 2019, shall retain that approval.

For purposes of the term "board certified," as used in this subparagraph, the terms "board" and "association" mean an organization that is an American Board of Medical Specialties member board, an organization with equivalent requirements approved by a physician's and surgeon's licensing board prior to January 1, 2019, or an organization

with an Accreditation Council for Graduate Medical Education approved postgraduate training program that provides complete training in a specialty or subspecialty.

(D) A doctor of podiatric medicine licensed under Article 22 (commencing with Section 2460) of Chapter 5 by the California Board of Podiatric Medicine may include statement that he or she is certified or eligible or qualified for certification by a private or public board or parent association, including, but not limited to, multidisciplinary board or association, if that board or association meets one of the following requirements: (i) is approved by the Council on Podiatric Medical Education, (ii) is a board or association with equivalent requirements approved by the California Board of Podiatric Medicine, or (iii) is a board or association with the Council on Podiatric Medical Education approved postgraduate training programs that provide training in podiatric medicine and podiatric surgery. A doctor of podiatric medicine licensed under Article 22 (commencing with Section 2460) of Chapter 5 by the California Board of Podiatric Medicine who is certified by a board or association referred to in clause (i), (ii), or (iii) shall not use the term "board certified" unless the full name of the certifying board is also used and given comparable prominence with the term "board certified" in the statement. A doctor of podiatric medicine licensed under Article 22 (commencing with Section 2460) of Chapter 5 by the California Board of Podiatric Medicine who is certified by an organization other than a boarder association referred to in clause (i), (ii), or (iii) shall not use the term "board-certified" in reference to that certification.

For purposes of this subparagraph, a "multidisciplinary board or association" means an educational certifying body that has a psychometrically valid testing process, as determined by the California Board of Podiatric Medicine, for certifying doctors of podiatric medicine that is based on the applicant's education, training, and experience. For purposes of the term "board certified," as used in this subparagraph, the terms "board" and "association" mean an organization that is a Council on Podiatric Medical Education approved board, an organization with equivalent requirements approved by the California Board of Podiatric Medicine, or an organization with a Council on Podiatric Medical Education approved postgraduate training program that provides training in podiatric medicine and podiatric surgery.

The California Board of Podiatric Medicine shall adopt regulations to establish and collect a reasonable fee from each board or association applying for recognition pursuant to this subparagraph, to be deposited in the State Treasury in the Podiatry Fund, pursuant to Section 2499. The fee shall not exceed the cost of administering this subparagraph.

(6) A statement that the practitioner provides services under a specified private or public insurance plan or health care plan.

(7) A statement of names of schools and postgraduate clinical training programs from which the practitioner has graduated, together with the degrees received.

(8) A statement of publications authored by the practitioner.

- (9) A statement of teaching positions currently or formerly held by the practitioner, together with pertinent dates.
- (10) A statement of his or her affiliations with hospitals or clinics.
- (11) A statement of the charges or fees for services or commodities offered by the practitioner.
- (12) A statement that the practitioner regularly accepts installment payments offers.
- (13) Otherwise lawful images of a practitioner, his or her physical facilities, or of a commodity to be advertised.
- (14) A statement of the manufacturer, designer, style, make, trade name, brand name, color, size, or type of commodities advertised.
- (15) An advertisement of a registered dispensing optician may include statements in addition to those specified in paragraphs (1) to (14), inclusive, provided that any statement shall not violate subdivision (a), (b), (c), or (e) or any other section of this code.
- (16) A statement, or statements, providing public health information encouraging preventive or corrective care.
- (17) Any other item of factual information that is not false, fraudulent, misleading, or likely to deceive.
- (i) Each of the healing arts boards and examining committees within Division 2 shall adopt appropriate regulations to enforce this section in accordance with Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

Each of the healing arts boards and committees and examining committees within Division 2 shall, by regulation, define those efficacious services to be advertised by businesses or professions under their jurisdiction for the purpose of determining whether advertisements are false or misleading. Until a definition for that service has been issued, no advertisement for that service shall be disseminated. However, if a definition of a service has not been issued by a board or committee within 120 days of receipt of a request from a licensee, all those holding the license may advertise the service. Those boards and committees shall adopt or modify regulations defining what services may be advertised, the manner in which defined services may be advertised, and restricting advertising that would promote the inappropriate or excessive use of health services or commodities. A board or committee shall not, by regulation, unreasonably prevent truthful, no deceptive price or otherwise lawful forms of advertising of services or commodities, by either outright prohibition or imposition of onerous disclosure requirements. However, any member of a board or committee acting in good faith in the adoption or enforcement of any regulation shall be deemed to be acting as an agent of the state.

(j) The Attorney General shall commence legal proceedings in the appropriate forum to enjoin advertisements disseminated or about to be disseminated in violation of this section and seek other appropriate relief to enforce this section. Notwithstanding any other provision of law, the costs of enforcing this section to the respective licensing boards or committees may be awarded against any licensee found to be in violation of any provision of this section. This shall not diminish the power of district attorneys, county counsels, or city attorneys pursuant to existing law to seek appropriate relief.

(k) A physician and surgeon licensed pursuant to Chapter 5 (commencing with Section 2000) by the Medical Board of California or a doctor of podiatric medicine licensed pursuant to Article 22 (commencing with Section 2460) of Chapter 5 by the California Board of Podiatric Medicine who knowingly and intentionally violates this section may be cited and assessed an administrative fine not to exceed ten thousand dollars (\$10,000) per event. Section 125.9 shall govern the issuance of this citation and fine except that the fine limitations prescribed in paragraph (3) of subdivision (b) of Section 125.9 shall not apply to a fine under this subdivision.

(Amended by Stats. 2017, Ch. 775, and Sec. 6. (SB 798) Effective January 1, 2018.)

Title 16 California Code of Regulations Section 1363.5

Advertising of Specialty Board Certification

(a) As used in this section,

(1) "Specialty board" means a board or association which certifies physicians in a specialty or subspecialty area of medicine.

(2) "Specialty or subspecialty area of medicine" means a distinct and well-defined field of medical practice. It includes special concern with diagnostic and therapeutic modalities of patients' health problems, or it may concern health problems according to age, sex, organ system, body region, or the interaction between patients and their environment. A medical specialty promotes the standards of practice within its specialty association.

(b) If a physician advertises that he or she is certified by a specialty board or association in a specialty or subspecialty area of medicine and that specialty board or association is not a member board of the American Board of Medical Specialties (ABMS) or does not have a postgraduate training program approved by the Accreditation Council for Graduate Medical Education (ACGME) or the Royal College of Physicians and Surgeons of Canada (RCPSC), then the specialty board or association shall be approved by the Division of Licensing and shall comply with all of the following requirements:

(1) The primary purpose of the specialty board shall be certification in a medical specialty or subspecialty. The specialty board shall encompass the broad areas of the specialty or subspecialty.

(2) The specialty board shall not restrict itself to a single modality or treatment which may be part of a broader specialty or subspecialty.

(3) If the specialty board certifies professionals other than physicians, the specialty board shall not represent either that (i) the criteria set forth in these regulations or (ii) the medical board's approval of the specialty board's certification program is applicable to nonphysicians.

(4) The specialty board shall be a nonprofit corporation or association, and it shall have at least a total of 100 members located in at least one-third of the states who shall possess a clear and unrestricted license to practice medicine.

(5) The specialty board shall have articles of incorporation, a constitution, or a charter and bylaws which describe its operation. The bylaws shall:

(A) provide for an independent and stable governing body with staggered, limited terms of not more than six years that is internally-appointed or selected by the members.

(B) set forth the requirements and policies for certification by the specialty board.

(C) require that the specialty board promote the public interest by contributing to improvement of medicine by establishing requirements and evaluating applicants who apply.

(D) require that the specialty board determine whether applicants have received adequate preparation in accord with standards established by the specialty board.

(E) require evidence that applicants have acquired capability in a specialty or subspecialty area of medicine and will demonstrate special knowledge in that field.

(F) require that the specialty board conduct comprehensive evaluations of the knowledge and experience of applicants.

(6) The specialty board shall have standards for determining that those who are certified possess the knowledge and skills essential to provide competent care in the designated specialty or subspecialty area.

(7) More than 80 percent of the specialty board's revenue for continuing operations shall be from certification and examination fees, membership fees and interest and investment income.

(8)(A) Except as provided in subparagraph (B) or (C) of this paragraph (8), the specialty board shall require all applicants who are seeking certification to have satisfactorily completed a postgraduate training program accredited by the ACGME or the RCPSC that includes identifiable training in the specialty or subspecialty area of medicine in which the physician is seeking certification. This identifiable training shall be deemed acceptable unless determined by the Division of Licensing to be either (1) inadequate in scope, content and duration in that specialty or subspecialty area of medicine in order to protect the public health and safety or (2) not equivalent in scope and content to the residency training required for board certification by any related ABMS board for the specific conditions, disease processes and surgical procedures within the scope of the applicant certifying board's examination and certification.

(B) If the training required of applicants seeking certification by the specialty board is other than ACGME or RCPSC accredited postgraduate training, then the specialty board shall have training standards that include identifiable training in the specialty or subspecialty area of medicine in which the physician is seeking certification and that have been determined by the Division of Licensing to be equivalent in scope, content and duration to those of an ACGME or RCPSC accredited program in a related specialty or subspecialty area of medicine. This training shall be evaluated by the Division of Licensing to ensure that its scope, content and duration are equivalent to those of an ACGME or RCPSC accredited program and are adequate for training in that specialty or subspecialty area of medicine in order to protect the public health and safety.

(C) In lieu of the postgraduate training required under subparagraph (A) or (B) of this paragraph (8), the specialty board shall require applicants seeking certification to have completed (1) a minimum of six years of full time teaching and/or practice in the specialty or subspecialty area of medicine in which the physician is seeking certification and (2) a minimum of 300 hours of continuing medical education in the specialty or subspecialty area of medicine in which the physician is seeking certification which is approved under Section 1337 and 1337.5 of these regulations. Any teaching experience acceptable under this subparagraph shall have been in a postgraduate training program accredited by the ACGME or RCPSC or that meets the standards set forth in subparagraph (B) that includes identifiable training in the specialty or subspecialty area of medicine to be certified. This training shall be evaluated by the Division of Licensing and determined to be equivalent in scope, content, and duration to those of an ACGME or RCPSC accredited program in a related specialty or subspecialty area of medicine and to be adequate for training in that specialty or subspecialty area of medicine in order to protect the public health and safety. Teaching or practice experience accepted

under this subparagraph shall be evaluated by and acceptable to the credentials committee of the specialty board pursuant to standards that are (1) specified in the bylaws of the specialty board and (2) approved by the Division of Licensing in accordance with criteria set forth in these regulations.

Physicians applying for certification who qualify under this subparagraph shall be required by the specialty board to have satisfactorily completed an ACGME or RCPSC accredited residency training program. This residency shall have provided training in the conditions and disease processes that are included in the new specialty.

Physicians who are certified by specialty boards under this subparagraph which are incorporated, or organized as an association on the effective date of these regulations, may advertise their board certification for three years from the effective date of these regulations. During that time, the specialty board shall demonstrate to the satisfaction of the Division of Licensing that there is in existence one or more postgraduate training programs that include identifiable training in the specialty or subspecialty area of medicine to be certified that meet the requirements of subparagraph (A) or (B) of this paragraph (8); then the specialty board's approval shall be permanent unless withdrawn under subsection (c). This training shall be evaluated by the Division of Licensing and determined to be equivalent in scope, content, and duration to those of an ACGME or RCPSC accredited program in a related specialty or subspecialty area of medicine and to be adequate for training in that specialty or subspecialty area of medicine in order to protect the public health and safety. If a specialty board cannot demonstrate its equivalency to ABMS boards in the three years following the effective date of these regulations, its members may not thereafter advertise certification by that board. This period may be extended for a year if the Division of Licensing determines that the specialty board is making a good faith effort towards achieving equivalency to ABMS boards.

Physicians who are certified by specialty boards under this subparagraph which are incorporated, or organized as an association after the effective date of these regulations, may not advertise their certification until the specialty board is determined by the Division of Licensing to be equivalent to ABMS boards. The specialty board shall demonstrate to the satisfaction of the Division of Licensing that there is in existence one or more postgraduate training programs that include identifiable training in the specialty or subspecialty area of medicine to be certified that meet the requirements of subparagraph (A) or (B) of this paragraph (8). This training shall be evaluated by the Division of Licensing and determined to be equivalent in scope, content, and duration to those of an ACGME or RCPSC accredited program in a related specialty or subspecialty area of medicine and to be adequate for training in that specialty or subspecialty area of medicine in order to protect the public health and safety.

(9) Except as provided in subparagraph (8)(C) above, at the time of application for approval to the Division of Licensing, a specialty board shall demonstrate that one or more postgraduate training programs are in existence and that these programs provide identifiable training in the specialty or subspecialty area of medicine in which physicians are seeking certification. This training shall be evaluated by the Division of Licensing and determined to be equivalent in scope, content and duration to those of an ACGME or RCPSC accredited program in a related specialty or subspecialty area of medicine

and to be adequate for training in that specialty or subspecialty area of medicine in order to protect the public health and safety.

The specialty board shall submit a plan that (A) estimates the number of physicians to be certified through subsection (b)(8)(C), above; (B) specifies the number and location of post graduate training programs developed and to be developed; the number of trainees completing the training annually; (C) demonstrates the equivalency of those programs, as provided for in subsection (b)(8)(B), above; (D) provides for monitoring to evaluate the quality of existing programs; and (E) allows for upgrading of the parameters of the specialty or subspecialty area of medicine to accommodate new developments.

Every year the specialty board shall report to the Division of Licensing its progress in implementing the plan for postgraduate training programs in the specialty or subspecialty area of medicine in which physicians are seeking certification. Failure to so report shall be grounds for withdrawal of approval by the division. Failure of a specialty board to establish to the satisfaction of the division that it is in compliance with its plan, as stated in its original submission to the division, shall be grounds for withdrawal of the division's approval of the specialty board. Failure of a specialty board to provide evidence that the postgraduate training programs are equivalent in scope, content and duration to those of ACGME or RCPSC accredited programs shall be grounds for withdrawal of the approval.

(10) The specialty board shall require all physicians who are seeking certification to successfully pass a written or an oral examination or both which tests the applicants' knowledge and skills in the specialty or subspecialty area of medicine. All or part of the examinations may be delegated to a testing organization. All examinations shall be subject to a psychometric evaluation. The examinations shall be a minimum of sixteen (16) hours in length. Those specialty boards which require as a prerequisite for certification, prior passage of an ABMS examination in a related specialty or subspecialty area, may grant up to eight hours credit for the ABMS qualifying board examination toward the sixteen (16) hour testing requirement.

(11) The specialty board shall issue certificates to those physicians who are found qualified under the stated requirements of the specialty board.

(12) The specialty board shall assist in maintaining and elevating the standards of graduate medical education and facilities for specialty training in medicine in collaboration with other concerned organizations and agencies, and have a mechanism for assisting accrediting agencies in the evaluation of training programs.

(c)(1) Upon request the Division of Licensing will approve a specialty board if it meets the criteria set forth in these regulations. The division may withdraw the approval of a specialty board if the division finds that it fails to meet the criteria set forth in these regulations.

(2) Within 30 working days of receipt of an application for specialty board approval, the division shall inform the applicant in writing that it is either complete and accepted for filing and referral to a medical consultant selected by the division or that it is deficient and what specific information or documentation is required to complete the application.

(3) Within 918 calendar days from the date of filing of a completed application, the division shall inform the applicant in writing of its decision regarding the applicant's approval as a specialty board.

(4) The division's time periods for processing an application from the receipt of the initial application to the final decision regarding approval or disapproval based on the division's actual performance during the two years preceding the proposal of this section were as follows:

(A) Minimum - 646 days.

(B) Median - 714 days.

(C) Maximum - 918 days.

(d) Specialty boards approved by the Division of Licensing shall certify every three years from the date of approval that they continue to meet the requirements of these regulations.

(e) The Division of Licensing shall conduct such evaluations as it deems appropriate to ensure that applicant boards applying to the division meet the criteria of these regulations.

Note: Authority cited: Sections 651 and 2018, Business and Professions Code; and Section 15376, Government Code. Reference: Section 651, Business and Professions Code; and Section 15376, Government Code.

HISTORY

1. New section filed 1-27-94; operative 2-28-94 (Register 94, No. 4).

2. Amendment of subsections (c)(2) and (c)(3) and new subsections (c)(4)-(c)(4)(C) filed 3-24-99; operative 4-23-99 (Register 99, No. 13).

This database is current through 9/28/18 Register 2018, No. 39

16 CCR § 1363.5, 16 CA ADC § 1363.5